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ABSTRACT

Reported were the results of a national study designed to identify and locate activity programs for retarded adults in the United States, to study comprehensively identified programs, to examine national, regional, state, and area standards, and to complete a monograph on activity programs. Findings of a 1964 report were compared with findings in the current report. Activity programs were defined as organized rehabilitation services providing training in daily living activities to severely retarded individuals beyond school age. Development of activity programs was covered briefly. Findings reported included stated broad purposes of activity programs, referrals, admission criteria, evaluation procedures, reasons for rejection, activity center population, reasons for discharge, waiting lists, program schedules, program activities, criteria for grouping, ratio of instructors to the retarded, planning program activities, evaluation of the retarded, counseling, transportation, cost of transportation, personnel, academic preparation of personnel, facilities, sponsoring or governing boards, volunteers, average cost to maintain an individual in an activity center, support of programs, and standards for activity programs. Minnesota was found to have the most activity programs. (CB)

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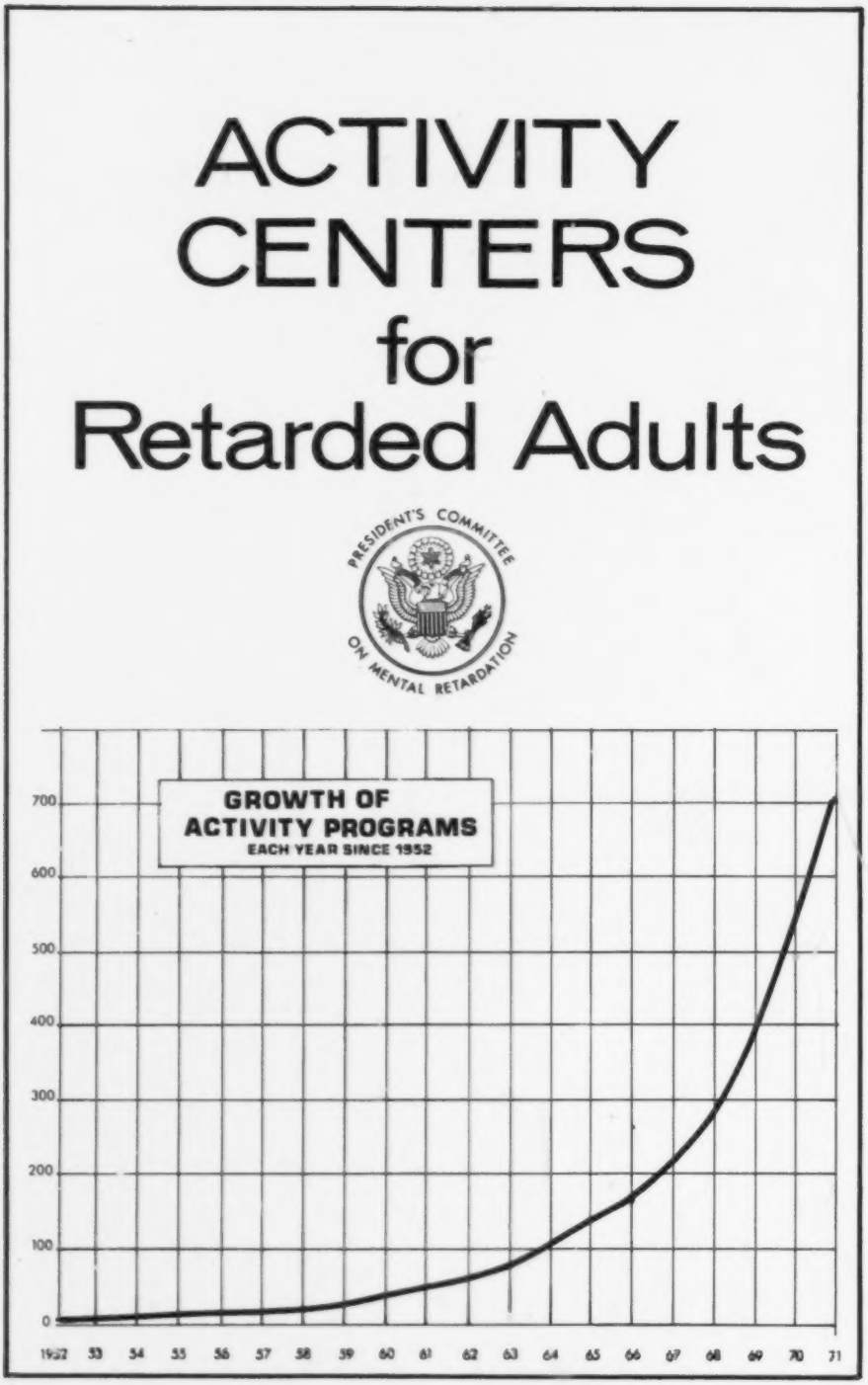
ACTIVITY CENTERS for Retarded Adults



THE PRESIDENT'S COMMITTEE ON MENTAL RETARDATION

EC 042 734

ACTIVITY CENTERS for RETARDED ADULTS

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under contract with

THE PRESIDENT'S COMMITTEE ON MENTAL RETARDATION

Washington, D.C. 20201

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PURPOSES OF THE NATIONAL STUDY

In July, 1971, the President's Committee on Mental Retardation sought an investigative and evaluative study on the activity program development for the retarded. What has been the growth and development of these centers? Have they grown as predicted? Where are they located and how are they organized and staffed? What are their roles in adult programming? Have the problems and weaknesses identified in the 1964 study been corrected? Are these programs licensed and inspected? Do they adhere to standards established on a national, regional, state and local basis? These and many other questions were the reasons why another national study of activity programs was initiated in July, 1971.

The study by the President's Committee on Mental Retardation was designed to accomplish the following:

1) Identify and locate activity programs in the United States.

2) Do a comprehensive study of the programs identified by analyzing data with regards to personnel, administration, organization, budget, and finances, program components and operation.

3) Make an examination of the national, regional, state and area standards and licensing practices and regulations with regard to activity programs.

4) Complete a monograph on activity programs in the United States which would include all of the above and also cover a review of empirical models and recommendations for staffing patterns of professional and supportive personnel.

The report that follows compares the present findings with the earlier 1964 National Study of Activity Programs findings and conclusions. A critical analysis is made of the present activity program development including standards. The recommendation for staffing models are based on the data obtained.

INTRODUCTION

Approximately eight years ago a nationwide examination of activity centers for the retarded was made for the purpose of determining the status and development of this important area of adult programming. The study was initiated in December, 1963 and completed in July, 1964. Prior to this nationwide study little had been written or was known about activity centers except that they were flourishing in numbers. For no comprehensive study had been undertaken and there was a sense of urgency to examine the issues that arise from an increase in new programs. It was felt that weaknesses and deficiencies needed to be identified and, if possible, remedied. Apropos of this, successful programs also had to be identified and the worthwhile experiences of these programs made available to all concerned. Accordingly, the first national study was undertaken in order to not only provide comprehensive knowledge on adult activity programs, but also recommendations for their future programming. At the time of the first study, activity centers were defined as follows:

> Activity programs are organized rehabilitation services for moderately and severely retarded individuals beyond school age (at least 16 yrs & older) who are not ready presently or who are too handicapped for a sheltered workshop. The centers provide training in basic daily living activities such as grooming, traveling, homemaking, and opportunities for better adjustment based on the retarded persons' needs in society and geared to the level on which they function. The training enables them to live with less dependence on others.

It was found in the first study that there were 94 activity centers in operation. Also, an additional 91 new programs were in various stages of planning. Sixty-eight of the 94 centers were studied in great detail. One thousand nine hundred thirty-four persons between the ages 16 - 62 attended the 68 programs. However, the average age of the persons served was 24 years and 4 months. The I.Q. range of the population was from a low of 12 to a high of 60, but the mean I.Q. for the whole group was 42. Inasmuch as the first national investigation of the centers was to provide comprehensive knowledge in a virtually unknown area of programming, it is not at all surprising that there were many important findings.

The following conclusions were made on the findings:

1) The rate of the development of activity programs can be expected to accelerate greatly.

2) The density of population factor is an important influence on the location of activity programs.

3) Activity programs are meeting a need in community programming for retarded persons too handicapped for a sheltered workshop.

4) The rationale of activity centers generally reflected the broad goals of the sponsoring associations.

5) The objectives of activity programs were similar to the objectives of public school special education programs for the trainable mentally retarded.

6) The selection practices of many centers were not consonant with the known characteristics, composition, and needs of the post-school group they serve.

7) Procedures in most activity programs were not adequate enough to enable staff to make a valid judgement on the eligibility of an applicant for admission.

8) Social and psychological services offered by these programs were grossly inadequate.

9) The activities considered important in programs were insufficient to attain the activity programs' stated objectives.

10) In most states, there is no single agency which has the responsibility for regulating activity programs with regard to staffing, program activities and other related aspects.

11) Nearly half of the staff of activity programs were not academically prepared or trained to work with the retarded.

12) Most activity programs as they now operate have serious weaknesses. There are also many unresolved problems, indeed, many not clearly understood.

One conclusion of the study was that the rate of the development of activity centers would accelerate greatly. Well, one of the first findings in the second study of activity programs really comes as a surprise. Although a rapid increase in the number of

programs was anticipated, no one even with the fondest expectations would venture or even hazard a guesstimate close to the number of programs that were actually located and identified. As of this date, 706 activity centers have been located throughout the United States, an increase of 612 programs in the very short span of just eight years, since the first study.

As with the first study, it was impossible to obtain complete information from all 706 centers on all aspects of programming and operations required for this study. However, the investigator was able to gather complete data from 422 programs, or about 60% of the centers. Based on the information supplied from these facilities, the population in attendance in the adult activity centers throughout the country can be projected at about 18,000 persons. The ages of these individuals range from as young as 14 years to over 65 years. The average age of the group as a whole is 25 years and 2 months. One finding in this study, in addition to the great increase in numbers, is that some activity centers are taking the retarded at an earlier age than in the first study. At that time the youngest age was 16 years. Now, 21 centers accept retarded persons at 14 years of age and 4 at 15 years. The range of the I.Q. of the population is from a low of 12 to a high of 65. The average I.Q. is 36. The range in I.Q's is greater in this latter study but the average I.Q. is down by 6 points from the first study.

What Are Activity Programs?

The best way to answer this question is to present the various definitions that are being used and to look at the characteristics of the population in these centers.

Activity programs have been defined as organized rehabilitation services providing severely retarded individuals beyond school age with training in daily living activities to enable them to live with less dependence upon others. The training starts at the level of performance related to the simplest of adult living skills and progresses to the point where these persons are able to assume increasing adult responsibilities (N.A.R.C. 1963.)

In drawing up minimum standards for activity programs, the Staff Development Project at the Center for Developmental and Learning Disorders of the University of Alabama Medical Center defines an Adult Activity Center as a facility where mentally retarded adults participate in organized, personally meaningful, programmed activities which help them toward an optimal adjustment to family and community.

The Michigan Department of Mental Health in establishing policies and procedures for activity centers defines activity programs as centers for mentally retarded adults over 21 years of age

who are considered to be currently ineligible for work activity centers or sheltered workshop programs.

In Louisiana an activity program is defined as a facility intended solely for the admission of students with mental retardation, who are provided with a program of education or training, handicraft, vocational, or recreational activities.

Adult activity programs are defined in Illinois as adult day training programs that operate on a full time basis. The objective of the program is to provide a therapeutic and educational environment for training the mentally and physically handicapped adolescent and adult. The activity program aids them in making the transition from school or institutional life to community acceptance.

The State of Kansas defines an adult activity center as a program that helps the developmentally disabled to develop and maintain a positive self concept as people with personal worth and abilities; to help them make the important transition into adult living in the community through training in adult independent living skills, and appropriate work skills. (Specifically for handicapped workers whose physical and mental impairment is so severe as to make their productive capacity inconsequential).

An activity center in Pennsylvania is defined as having for its major objective a productive and meaningful program in order to help the adult individual develop a relative degree of independence. Such a program should have as its primary concern the needs of the individual as he attempts to cope with the growing complexities of his environment. Through a comprehensive program which offers daily-living and work-training, counseling, psychological, psychiatric, medical and social services, the individual can attain an increasing level of socialization and normalization.

In New York City the Occupation Day Center is an activity center designed specifically to serve the retarded adolescent or adult. The Center has developed a six-phase program which includes travel training, grooming and selfcare, orientation to the community, domestic skills, academic instruction, and work for pay.

Activity centers in Indiana are for retarded persons 16 years and older. The program includes training in basic living activities, work experience and controlled working conditions geared to preparing trainees to enter a sheltered workshop or other employment.

In reviewing these definitions of activity centers it appears that such programs have been developed for retarded persons considered to be too handicapped for a sheltered workshop program.

These persons have been described as having one or more of the following characteristics:

1) Unable to participate meaningfully in the social life of a sheltered workshop

2) Intellectually limited with I.Q.'s below 40, thus generally unable to participate adequately in work-oriented environments; and

3) Unable to cope with some basic skills of independent living, (Tobias and Cortazzo, 1963).

Development of Activity Programs

Community provisions for the post-school age retarded apparently began expanding in the decade of the 1950's. The impetus for these rehabilitation movements came about because of the concern of parents and associations for the retarded. During the early years of the National Association for Retarded Children much of the efforts of many local associations were directed toward conducting demonstration educational programs for school age retarded children. With the successful demonstration of educating these children, the public schools began to assume this responsibility for education. As a result, an interesting situation was created because many local associations which were organized to provide educational services found that their major purpose was accomplished. Consequently, many associations turned their attention toward other problems - the above school age retarded group; the pre-school age group and the profoundly retarded of all ages. Because of this situation, community provisions for the post-school age retarded gained in popularity.

Two important community developments in the rehabilitation of retarded persons occurred in the 1950's. The first development was the utilization and expansion of sheltered workshops as a training resource for the vocational rehabilitation of the retarded; the second development, which began several years later, was the establishment of activity centers for the rehabilitation of the retarded considered to be too handicapped for a sheltered workshop program.

The initial orientation was towards sheltered workshops as the optimal training device for the post school age retarded. It was found that some of the post-school age retarded (50 - 75 I.Q.) classified as "deferred placeable" needed additional vocational training and related services before they could qualify for competitive employment. Moreover, it was discovered that there were retarded persons in the lower educable range (50 - 60 I.Q.) and in the higher trainable range (40 - 50 I.Q.) who, upon reaching a working age, could do remunerative work only in a sheltered environment. Persons in this group were classified as "sheltered employable."

The 1954 amendments to the Vocational Rehabilitation Act (P.L. 565) sparked many associations for retarded children to establish and operate sheltered workshops for the retarded. In addition, the Federal government financially supported research and demonstration projects in the area of rehabilitation. This assistance gave rise to over 1000 workshops which serve the retarded throughout the country. Although the workshops varied in size, staff, and nature of training programs, most had two closely related common objectives:

1. To train for competitive employment those retarded adults who prove suitable for such training

2. To provide long term or permanent employment for retarded adults whose work skills are not minimally acceptable to competitive industry.

Thus with no adequate precedents to follow, criteria for admission to the workshops were kept purposefully flexible and were frequently determined on an ad hoc basis. However, as these programs gained in experience and were able to evaluate the progress of long term clients, it became evident that there were many who could use more profitably a program with a different emphasis. Where the skills of daily living in the community were grossly deficient, it seemed pretentious to place major stress on vocational training.

Also, during this first rehabilitation movement there were an increasing number of states which as a result of legislation were authorizing or permitting the organization and expansion of public school services for trainable children of school age. This situation created a tendency among families to keep their trainable retarded children at home, especially during the period of adolescence. However, as these persons reached young adulthood (17 - 18) they were customarily discharged from school. Generally the reason given was that they were no longer able to profit from the school program.

What occurred then was that the years 17 - 20 represented a genuine crisis for many families with trainable members in this age group. These persons who had been kept occupied in school were now without service and in need of care. It was not unusual for their parents to think more and more of institutionalization as these persons grew older. The actual rate of institutionalization increased sharply during the years between 20 and 24. Sheltered workshops were hard pressed to accept persons from this group, but it became increasingly obvious that most persons in this group were not eligible for a working program.

To meet the specific needs of severely retarded adults, associations for the retarded began establishing activity programs in

the mid 1950's. The year 1952 marked the beginning of activity centers for the retarded in this country. Two years later, in 1954, three more centers were established. The first programs established by associations for retarded children were designed to develop the retarded socially, to prepare them for sheltered workshops and to train them to become useful in their homes. Although activity centers had their start in 1952, the growth of these programs was steady but slow until 1960 when the movement began to gain impetus.

The most rapid growth of this movement began in 1964 when 28 new centers were established. Since 1964 there has been a substantial increase in the number of new centers established each year with the exception of the year 1966 when there were 16 fewer programs established than the previous year. However, the development of new programs took a sharp rise again in 1967, and this rise continued through 1971. For example, in 1968 there was an increase of 77 new programs; in 1969 an addition of 109 new centers and in 1970 an increase of 145 centers. In all, over 600 new programs were established in an eight year span beginning with the year 1964.

Minnesota has the most activity centers, 86, of any State in the nation. It is followed next by New York which has 50 activity programs. Ohio and Indiana each come close to New York in that they have 45 and 43 activity centers respectively. Next in order in terms of centers are as follows: Illinois (28); Florida (27); Kentucky (26); California (23); Connecticut and Georgia with 21 each; Iowa and Kansas each with 19 activity centers. Washington has 18 activity facilities; Maryland follows with 16 programs; Michigan, Colorado, Pennsylvania and North Carolina all with 14 centers each. Other States which have more than 10 centers each include Nebraska, New Jersey, Oregeon, Rhode Island, South Carolina and Louisiana.

Although Pennsylvania was the first State to establish an activity program, the activity program movement has not grown as rapidly in this State as one would expect for such a large State. In New York State under the able leadership of Mr. Jerry Weingold, Executive Director of the New York State Association for Retarded Children, the Occupation Day Center was established in 1958 on a part time basis. In the spring of 1959, the New York City Chapter of the New York State Association applied for and received a grant from the National Institute of Mental Health for the purpose of conducting a full-time program at the Occupation Day Center to demonstrate the effectiveness and value of such an activity program for the moderately and severely retarded. Since 1959 the Occupation Day Center has provided leadership in disseminating information to other centers in the country. The Occupation Day Center's program brought demonstrable improvements in adaptive behavior and in the acquisition of functional skills for a significant proportion of the trainees. Moreover, the Center achieved

a stable position in the chain of community services for the retarded, and the facility and its program became a prototype for similar facilities in other parts of the country.

The Independent Living Center in San Francisco under a Federal grant also provided leadership to the States in the western part of the country in developing new activity programs.

Of all the States, Minnesota has taken the lead in not only having the most activity centers but also in the important area of establishing standards for the operation of these programs. The other States which follow closely behind Minnesota in the number of programs also, like the leader, provide grant-in-aid subsidies to these programs and most have also developed fairly comprehensive guidelines for the operation of activity centers.

Stated Broad Purposes of Activity Programs

In the first study, fewer than one-third of the activity centers had a written statement of purpose. Four-fifths of the centers in the later study now have written statements of purpose. This is a very substantial and positive increase. Table 1 shows a comparison between the stated objectives of activity programs in 1964 and in 1971. It is interesting to note that the percentage of responses for some of the objectives has changed considerably since the 1964 study.

The stated purpose—"The severely mentally retarded have a potential and are entitled as human beings in our society to have their potential developed to capacity. It is the responsibility of society to develop and make maximum use of their potential"—remains at the top of the list for the greatest number of programs in both studies, although it has slipped in percentage points from 71 per cent in 1964 to 60 per cent in this study.

TABLE 1

COMPARISON OF STATED PURPOSES OF ACTIVITY PROGRAMS

STATE PURPOSE	1964 (N = 68 Programs) NUMBER OF PROGRAMS	1964 (N = 68 Programs) PERCENTAGE	1971 (N = 422 Programs) NUMBER OF PROGRAMS	1971 (N = 422 Programs) PERCENTAGE
The severely mentally retarded have a potential and are entitled as human beings in our society to have their potential developed to capacity. It is the responsibility of society to develop and make maximum use of their potential.....	48	71	253	60
The severely retarded can remain at home in the community but their parents need help and assistance to keep them at home	37	55	130	31
Provide mentally retarded with satisfying experiences and activities during the day to make them happy ...	26	38	63	15
Keep the mentally retarded occupied and supervised during the day in a socially acceptable way	17	25	154	36
Help the retarded become less dependent, especially on their parents, through extended training.....	16	24	172	41

TABLE 1

COMPARISON OF STATED PURPOSES OF ACTIVITY PROGRAMS (Cont'd)

STATE PURPOSE	1964 (N = 68 Programs) NUMBER OF PROGRAMS	1964 (N = 68 Programs) PERCENTAGE	1971 (N = 422 Programs) NUMBER OF PROGRAMS	1971 (N = 422 Programs) PERCENTAGE
Help parents better understand their retarded so that the retarded may achieve a greater degree of independence.....	13	19	63	15
Prevent further deterioration of the personality of the retarded	3	04	34	8
The activity program is a continuation of public school.....	2	03	42	10

The objective—"Help the retarded become less dependent, especially on their parents, through extended training" —made the biggest gain both percentage wise and in terms of the numbers of programs that had it listed as one of their objectives. Another objective— "To keep the mentally retarded occupied and supervised during the day in a socially acceptable way" —gained substantially in this study over the last in both numbers of programs and also in percentage. Two objectives— "Provide mentally retarded with satisfying experiences and activities during the day to make them happy" and "Help parents better understand their retarded so that the retarded may achieve a greater degree of independence"—decreased in terms of the percentage of centers which listed them. One interesting observation made with respect to stated purpose is that 42 centers in this study see the activity program as a continuation of public school. Although this was only ten per cent of the programs studied, it was a sizeable increase over the two centers stating this purpose in 1964.

Objectives

Numerous and very specific objectives were given for the programs. Table 2 classifies the responses into five major categories.

As one would suspect, the vast majority of centers had social development and work preparation as their objectives. There was also a sizeable increase in the percentage of centers which had personal and family adjustment as one of their objectives. In most of these centers, counseling and guidance were provided to the parents and the retarded. Their aim was to develop positive attitudes of parents toward their retarded members.

TABLE 2

BROAD OBJECTIVES OF PROGRAMS

CATEGORIES	1964 NUMBER OF PROGRAMS	1964 PERCENTAGE	1971 NUMBER OF PROGRAMS	1971 PERCENTAGE
Social Development	42	62	338	80
Personal and Family Adjustment	35	51	262	62
Work Preparation	55	81	359	85
Training in Other Areas Than for Work	53	78	311	76
Relief for Parents	41	60	232	55
Recreation	27	40	253	60

Sixty per cent of the centers had recreation as one of their goals. This is an increase of 20% over the first study.

Under the category of Work Preparation, the centers had as the major goal to train those retarded who were capable of eventual sheltered workshop placement. Still another goal in some programs was to provide some work experience, no matter how minimal, to the more seriously retarded even though they possibly would never be ready for a sheltered workshop. In these situations, it was felt that even the more severely intellectually handicapped should be permitted some satisfaction from doing work for remuneration, no matter how little it was.

In the area of Relief for Parents, most programs which had this objective felt that parents need "a break" from their retarded sons and daughters for a part of the day. With the retarded in a

program and out of the home, the parents were able to take care of their home responsibilities and, in some cases, take part in community, civic and social functions. Some centers also emphasized the point that parents who wanted to keep their retarded family members in the community should not be penalized, but assisted to achieve this goal.

Table 3 shows the goals of training in other areas than for work. As would be expected, the vast majority of centers had grooming and useful home skills as major training goals.

TABLE 3

GOALS OF TRAINING IN OTHER AREAS THAN FOR WORK

	1964 N = 68 PROGRAMS		1972 N = 422 PROGRAMS	
	NUMBER OF PROGRAMS	PERCENTAGE	NUMBER OF PROGRAMS	PERCENTAGE
Grooming	53	78	381	90
Useful Home Skills	48	71	367	87
Communicative Skills	37	54	261	62
Arts and Crafts	28	41	229	54
Community Skills	26	38	245	58
Academics	25	37	181	43
Woodworking	11	16	148	35
Travel Training	8	12	190	45
Music	3	04	89	21
Ceramics	1	01	59	14

More than one-half of the centers had communicative skills, arts and crafts and community skills as training objectives.

Referrals

Ninety - six per cent of the programs had accepted retarded persons who were referred directly by parents. The next highest source of referrals, ninety-four per cent,came from the public schools. These also were the leading sources in 1964, but an important finding in the new study was the substantial increase in the number of referrals from institutions and vocational rehabilitation agencies. This finding is of considerable interest in that it appears that activity centers have established themselves as a vital link in the continuum of services and programs for the retarded. Certainly, the activity centers have given institutionalized retarded opportunities to return to the community. Similarly, they have become acceptable referral resources for rehabili tation agencies. In the 1964 study the lack of use of activity centers by rehabilitation agencies and institutions was a serious concern at that time. Referrals to activity centers were also made by public health nurses, physicians, mental health, child guidance clinics and family agencies.

Admission Criteria

Slightly more than one-half of the centers had established a lower range of 16 years. The youngest age a person was accepted was 14 years. Five per cent or 21 centers had established this as a minimum age and these were programs that were operated in conjunction with trainable classes in public schools. Four programs had set a minimum age of 15 as the youngest age they would accept.

Thirty-eight other centers had no minimum age; however, they did not have persons younger than 16 in their centers. Most programs, 69 per cent or 291 centers, had not established a maximum age. Again, however, those programs which were operating in cooperation with the schools did set 21 as the upper age in program.

Three-fourths of the centers required that the applicant have mental retardation as the primary handicapping condition. In the first study, all centers had this criterion. Ten per cent had either retardation or a physical handicap as the criterion. Table 4 reveals some interesting results. Namely, it appears that what seemed to be important criteria for admission in 1964 in most centers had been played down as non-essential in 1971. Is this a result of our experience or of our better program techniques and methods? Or is it because the applicants who apply are more advanced in their self-help skills than those in the first study because of greater training opportunities for them today? Perhaps all or some combination of these reasons may be the answer.

TABLE 4

OTHER CRITERIA FOR ADMISSION

CRITERIA	1964 NUMBER OF PROGRAMS	1964 PERCENTAGE	1971 NUMBER OF PROGRAMS	1971 PERCENTAGE
Mental Retardation Primary Condition	68	100	317	75
Mental Retardation Or Physical Handicap	--	--	42	10
May Have Secondary Disability	68	100	63	15
Toilet Trained	66	97	63	15
Care for Self Needs	65	96	55	13
Ambulatory	63	93	51	12
Able to Communicate	60	88	42	10
Able to Follow Directions	58	85	21	5
Must Travel	47	69	13	3
Climb Steps	3	04	4	1
Resident of County	--	--	21	5
Able to Benefit	--	--	63	13
Good Health	--	--	63	15
Not Eligible for Other Program	--	--	76	18
Emotionally Stable	--	--	46	11

Although all centers claimed that they accepted persons with secondary handicaps, there seemed to be a very small percentage of programs that had deaf persons. Again, most centers had accepted persons with cerebral palsy and epilepsy. Over 70% of the activity centers accept persons with visual and auditory impairment.

Seventy-six per cent of the centers had not set a minimum I.Q. requirement as part of the admission criteria. Some programs indicated that they had persons with I.Q.'s as low as twelve.

No upper I.Q. was set for the centers but most depended not on I.Q. scores but the functioning ability of the retarded.

Evaluation Procedures

Almost every activity center requires that an application be completed and the applicant have a medical evaluation as part of the admission process. This second study shows that there is now greater emphasis on the social history, visual, hearing, speech, educational and vocational evaluations. Likewise, there has been a very marked increase in the importance of providing a trial period as a part of the evaluation procedures. The lack of a trial period in many centers was a glaring weakness found in the first study.

Full staff meetings for applicant evaluation appear to be the common practice in most centers. They are used to assess the accumulated data to determine if the applicant can benefit from the program and if he meets the admission criteria. The director or supervisor in charge makes the final decision (acceptance or rejection) on the application, but nearly all the centers reported that in most instances, he gives a routine "stamp of approval" to the recommendations emanating from the staff conference.

Reasons for Rejection

Eighty-nine centers had not rejected any applicant for their programs. However, 333 centers did reject 889 applicants for a wide variety of reasons. The major reason for not accepting an applicant was "too high mentally for the program." The other major causes for rejection of an applicant were emotional disturbance, physically too handicapped and no transportation. In the 1964 study most rejections of applicants were made because of emotional disturbance, too high mentally for the program was the next prevalent reason followed by mentality too low to benefit and then by the reason that applicants were physically unable to participate.

It is surprising to find that in 1972 no transportation would still be a major reason for rejection.

The Activity Center Population

Persons accepted into the activity centers were generally called "trainees" in three hundred and two centers. The next widely used descriptive term was "clients" in eighty-five centers. In 35 programs, the most common term used was "students."

When the results of the first study in 1964 were completed, there were 1,154 retarded adults in 68 activity centers in thirty states. Six hundred and forty-two were males and five hundred and twelve were females. The age range of the activity program population was from sixteen to sixty-two years, with an average age of twenty-four years and four months. The I.Q's of the population ranged from a low of twelve to a high of sixty and a mean I.Q. of forty-two.

This second study 8 years later documents the tremendous growth of activity programs. In the 422 centers, there were 13,495 persons. Fifty-three per cent were males and 47 per cent were females. The range of ages was from 14 years to over 65 years. The average mean age was 25 years, 2 months. With regard to I.Q.'s of the population, the range was from a low of 12 to a high of 65. The mean I.Q. was 36.

The number of trainees in the various centers ranged from four to one hundred sixteen. (In areas where there was a central center and several satellites as in New York City, each facility was considered as a separate facility in determining the number of persons in the program.) The modes are as follows: 54 centers had between 31 - 35 persons, 53 between 21 - 25, 46 between 16 - 20 and 38 had between 26 - 30.

Reasons for Discharge

There were no discharges in twenty-nine centers. The remaining centers had a total of 2,085 persons discharged for a variety of reasons. The major reasons for termination were: 1) the retarded were placed in employment, 2) the emotional problems were too great for the program staff to handle effectively, 3) parents did not accept the activity program, 4) the retarded had serious medical problems, and 5) transportation problems.

Employment in sheltered workshops was the biggest reason for discharge from programs. A sizable number, 1,336, were terminated for this reason.

Waiting Lists

A considerable number (228) of activity centers had no waiting lists. One hundred ninety four which reported that they had waiting lists had a combined total of 1,946 applicants for admission.

Seventy-five centers had from 1-5 persons on the waiting list, 42 had from 11-15 persons, and 40 had between 6-16.

The centers' waiting lists ranged from as few as two applicants to well over one hundred applicants.

Program Schedules

Nearly all the centers were in operation at least 10 months per year. Slightly over 60 per cent were opened 11 months per year. There were 22 centers that were operated on a nine month basis.

The weekly schedule in programs ranged from two days a week, part-time to five full days. Twenty-five centers were on a two or three day a week schedule. Many of them were operating in this way because of space, financial reasons, and demand for service problems. About 75 per cent of the centers were on a five day a week schedule.

The daily schedule ranged from 2 hours a day to 9 hours. The vast majority of centers had from 6 to 8 hours of program time each day.

Program Activities

The training activities provided in the 422 centers varied considerably in kind and number, but can be grouped under the areas of, (1) self-care and grooming, (2) useful home skills, (3) community skills, (4) communication, (6) recreation, (7) arts and crafts, (8) academic instruction, and (9) remunerative work.

When one compares the 1964 and 1971 study findings on types of training activities provided, a change of emphasis in the area of self-care - grooming is readily noticeable. In 1971 the programs reported very little emphasis on the basics of dressing such as lacing and tying shoes, training in buttoning and using a zipper and so on. Instead there was considerable attention placed on the different styles of dress,the application and use of make-up, deodorants, perfume and grooming. Personal hygiene, safety and first aid also received much greater emphasis.

In the training program area of useful home skills, meal planning and cooking moved up to first rank in 1971. In 1964 it was third, following washing dishes and use of cleaning equipment.

The 1971 study showed a greater emphasis on training activities in the academic areas. A much higher percentage of centers responded that they instructed the retarded in making change, telling time, filling out applications and so forth. One change that was noted in the later study is that the academics were taught in relation to work. For example, instruction in time telling was stressed as follows: What time do you have to be to work in the

Center? Show me where the big and small hand would be at that time? What time is lunch, coffee break and so on? In this way it was felt that the learning would be based on an intrinsic need and it would also have more meaning for the retarded.

Dancing and parties were the most popular recreation activities in 1964. At that time more than one-half of the centers provided dancing and slightly fewer than one-half felt that parties were important. Table games, such as checkers, picture dominoes, lotto, color bingo and many others were a part of the recreational program in two-fifths of the centers. Basketball, swimming, bowling and excursions were considered important in more than one-third of the responding centers.

The 1971 study showed bowling and spectator sports making the largest gains. They passed dancing and parties in popularity, but the latter also made percentage gains.

Under community skills in this recent study, activities which stressed the use of recreation facilities and dining out in restaurants, cafeterias, coffee shops and other places were carried on in over 80 per cent of the programs. shopping in 69 per cent. There was also a large increase in the number and percentage of centers which provided instruction in travel training and community courtesies. The latter includes, for example, greeting a friend, and when and how to apologize to others when one mistakenly talks out of turn or steps on someone's foot.

A much larger percentage of centers provided training activities in the area of communication than in the first study. Significant percentage gains occurred in the numbers of centers that provided group discussion and that used current events, and there was an expecially large increase in instructing the retarded in the use of the telephone. Substantial gains with regard to number of programs providing speech therapy and language development also were noted.

Remunerative work continued to be a very popular training objective in the vast majority of programs. Eighty-two per cent of the centers engaged in sub-contract work, compared to 75 per cent in 1964. In the first study the contracts involved operations of collating, assembling, lacing and sorting. This study revealed that the retarded were engaged in more difficult types of subcontact work.

For example, in some places the retarded were assembling elec tronic parts for various commercial projects for consumers. In still other centers the severely retarded were operating electric power-driven drill presses, band saws and other power tools.

All in all there seemed to be more diversified contracts being offered to the retarded than in the initial study. Nevertheless, many activity centers continued to accept contracts for operations such as collating, sorting, packaging, pasting and so on.

The percentage of programs making salable products rose from 38 to 51. The products included holiday corsages and greeting cards, center pieces, ash trays and other ceramics, wood products, sewing products, such as aprons, pot holders, pencil holders, leather and paper products, and flower arrangements.

Approximately 30 per cent reported that they provided training in service occupations. The ones listed were messenger, porter, kitchen helper, food handler, stock clerk, instructor's aide and maids. Sixty-three programs or fifteen per cent performed salvage operations as part of their work program. Some operations included sorting and bundling of rags, reclaiming useful parts from used electronic equipment and electrical appliances and instruments.

More programs were giving instruction in the different crafts than in the first reported study. There were increases in all areas except weaving. The greatest increases were in ceramics and art. Ceramics went from two to 34 per cent and art from two to 25 per cent.

Criteria for Grouping

Although there was a wide range of training activities conducted by the centers, 30 programs did not establish different ability level groups. These centers arbitrarily divided the retarded into groups for activities. The majority of programs did use various predetermined grouping criteria. The functioning level, social ability and interest were the criteria used most. These appear to be appropriate ways of grouping adults for program activities. Mental age was used the least.

Ratio of Instructors to the Retarded

The ratio of instructors to the retarded in programs ranged from one instructor to three persons to one for 20, with a ratio of one to 10 most prevalent. However, these figures must be used with caution in that other personnel and volunteers were included in some centers as instructors; for example, 26 centers reported that the director also assumed responsibility for instructing the trainees. Volunteers were used in nearly all programs to augment the staff.

Planning Program Activities

Most centers, about 80 per cent, planned the program activities on a weekly basis. About five per cent planned activities daily and 15 per cent planned activities on a monthly schedule.

Twenty six per cent, or 68 centers, used their entire staff in the planning process. Sixty-seven per cent, or 283 programs, had the staff working directly with the trainees, such as instructors planning the program for their particular group. Most centers did indicate that other staff persons such as psychologists, social workers and consultants from time to time provided them with assistance in planning and evaluation.

Evaluation of the Retarded

Nearly all centers, 416, reported that the retarded persons were evaluated in a systematic manner. About 50 per cent had this done on an annual basis whereas 28 per cent scheduled the assessments every six months. Evaluations were completed quarterly in 12 per cent of programs and in another 10 per cent on a monthly time basis.

About 80 per cent indicated that the evaluations were completed in writing and they became a part of the permanent trainee's record.

Counseling

The large majority of centers, 317, offered counseling to the retarded and 183 of them also provided this service to the parents as required. Forty-five centers did not offer counseling. Both individual and group counseling, depending on the circumstances, were included in the counseling program. Training goals and their interpretation, special problems both in the program and at home, personal and social adjustment, placement into another program were some of the reasons for counseling. Parents were selected for counseling based on problems, common goals and by request.

Generally, the program staff conducted the counseling for parents and the retarded. However, other resources such as consultants and resources also provided this service.

Transportation

One hundred eighty-five out of 422 centers did not provide transportation for the retarded attending. The parents were responsible for transporting their sons or daughters personally or making other arrangements.

In the 1964 study, twenty-one centers provided transportation for 211 persons. The second national study showed that 237 programs transported 1,828 persons daily.

Cost of Transportation

In 1964 the cost of one round trip transportation for each person from his home to the program ranged from a low cost of

$.40 to a high of $5.00. The average round trip cost was $1.25. Seven years later in 1971, the average round trip fare ranged from $.25 to a high of $6.00, with the average cost $1.60.

Personnel

In reviewing the 1964 study against this most recent national examination it is quickly discernible that there has been a substantial or significant improvement in the numbers of professional staff for these programs.

In 1964, 64 centers employed 162 full-time and 79 part-time employees and 10 consultants. Fewer than two-thirds of the programs indicated that they had a full-time director. Just over 150 said they had a part time director. Only 16 facilities listed an assistant director on staff. Thirty supervising instructors were employed full-time in 26 centers and two supervisors were on part-time employment in an additional five programs. Overall there were 94 instructors in 51 facilities. Sixty-nine were on a full-time basis in 36 centers and the remaining instructors were employed part time in 15 programs.

In this first study very few centers employed social workers, psychologists, speech therapists and evaluators. Only a total of 15 social workers, two speech therapists and six psychologists were employed by the centers. Very few programs had the services of nurses and physicians as consultants.

The activity program director in 19 centers had a dual role in programs. He not only was responsible for directing the center but also for instructing a group of retarded persons. Likewise, all supervising instructors also were responsible for a group.

The 1971 study shows that most facilities now have a full-time director and almost all the remaining centers have at least a part-time director. Twenty-one per cent also have an assistant director. About one-fourth have a full-time social worker and 32 per cent have at least a part-time social service worker. Eighty-eight per cent had supervising instructors, 71 per cent on a full-time arrangement. All centers indicated that they had instructors. In fact, 522 were employed in the facilities. Thirty-two per cent had psychologists available but mostly on a part-time basis. Teachers were employed in 30 per cent of the centers full-time and in 10 per cent of the facilities on a part-time schedule.

Academic Preparation of Personnel

In 1964, out of 59 directors, 22 had only a high school diploma. Only one-half of the assistant directors had at least a college degree. About the same percentage of the supervising instructors had a high school education or less. And more than one-third of the instructors had only a high school education.

The results for the 1971 study are indeed encouraging. For example, 286 out of 374 directors and 62 out of 110 assistant directors had college degrees. There was also considerable improvement in the academic preparation of other staff such as social workers, supervising instructors, speech therapist, psychologist, nurses and so on.

Facilities

Facilities used for the activity programs varied greatly among the centers. The results of the 1971 study show that there is greater use of churches, community centers, commercial buildings and day care centers. There has been a very large increase in the number of activity centers which own their own facilities. Ten per cent of these buildings were designed especially for the activity program. Greater utilization is made of schools, workshops and regional centers for these programs. In fact, where there were no reported programs using the regional centers in the 1964 study, this study reveals that there are 21 programs located in regional centers.

Sponsoring or Governing Boards

In 1964, 80 per cent of the activity centers were sponsored by associations for retarded children. The board of directors of the association also governed the activity centers. Only 12 per cent of the activity programs had their own board of directors which governed all their policies and operations.

There has been a considerable change since 1964 in the sponsoring and governing groups of these programs. Today, about 48 per cent are governed by an association for retarded children board of directors. More and more activity centers now have become incorporated as non-profit corporations with their own board of directors.

There also seems to be an interest in sponsoring activity centers shown by other groups, such as workshops, service clubs and county rehabilitation services. County boards on mental retardation, divisions of retardation, health departments and county mental health departments are also sponsoring and governing about 15 per cent of these centers.

The boards of directors of about 75 per cent of the centers or sponsoring groups meet monthly to transact business and set policy for the activity centers. Approximately 14 per cent meet on a quarterly basis and the remaining 11 per cent meet bi-monthly.

Sixty-eight per cent of the boards had written policy pertaining to program, personnel practices, financing and budgets, tuition and other aspects of activity programs.

Volunteers

In 1971, volunteers were utilized in 82 per cent of the programs. Three hundred forty-six centers had 2,396 volunteers. In 1964, fifty-four centers used 341 volunteers to supplement staff in their activities, and 76 centers reported that they did not use volunteers.

Most centers had a definite schedule of days, hours and assignments for the volunteers. Also, in nearly all centers, volunteers were supervised by the professional staff.

All centers that had volunteers felt that they were a great asset to the program and staff.

Average Cost to Maintain an Individual in An Activity Center

The average cost to maintain a retarded person in activity centers on a yearly basis ranged from $751 to a high of $4500. Most centers, 261, were in the cost range from $1251 to $3150 per year to maintain a person in a program. Compared to the 1964 results, this study shows that activity centers today are spending more per individual in programs. The modes in this area were that 35 centers spent from $1351 to $1450; 33 from $1251 to $1350; 29 from $1651 to $1750; 25 from $1251 to $2250, and another 25 from $1551 to $1650.

The 1964 study found the average cost per person in fifty nine centers to range from $250 to over $1500. However, in that study, 27 of those centers had an average cost range from $651 to $950.

Support of Programs

Funds to pay for the cost of operating activity programs came from a variety of sources. Two hundred ninety-six of the 422 centers studied received State subsidy or aid ranging from 10% to 100% of their total budget. Ninety-seven programs received county aid or subsidy ranging from 10% to 80% of their budgets. Federal grants to programs still played a substantial role in supporting 151 centers.

Public school boards of instruction supported 42 centers for 50% of their operational costs and 20% of their total costs. Mental health, rehabilitation agencies and model cities were also supporting some programs in varying degrees. Other sources were United Fund, donations, and contracts or sale of articles.

Standards for Activity Programs

Twenty-three states have developed guidelines and standards pertaining to the operation of adult activity programs. Five states

reported that they did not have established standards nor were they in the process of establishing such guidelines. However, 10 states did respond that they were in the process of preparing guidelines and standards for their centers. Unfortunately, 12 states did not reply even though the investigator made several follow-up requests. Table 5 contains a list of the states and the status they are presently in with respect to the development of standards for activity centers. There are no established national

TABLE 5

STATES WITH STANDARDS FOR ACTIVITY PROGRAMS

STATE	YES	NO	STANDARDS IN PROCESS	NO RESPONSE	STATE AGENCY RESPONSIBLE FOR STANDARDS
Alabama	X				Department of Mental Health
Arizona		X			Department of Public Welfare
Alaska		X			
Arkansas	X				
California	X				
Colorado					
Connecticut	X				Office of Mental Retardation
Delaware				X	
D.C., Washington					
Florida		X			Division of Retardation
Georgia	X				
Hawaii					Division of Retardation
Idaho					
Illinois			X		Local Licensing and Zoning Reg.

TABLE 5 (Continued)

STATE	YES	NO	STANDARDS IN PROCESS	NO RESPONSE	STATE AGENCY RESPONSIBLE FOR STANDARDS
Indiana	X				Division of Retardation
Iowa		X			Department of Social Services
Kansas	X				
Kentucky			X		
Louisiana	X				
Maine					
Maryland			X		Department of Health and Mental Hygiene
Massachusetts					
Michigan	X				Department of Mental Health
Minnesota	X				Department of Mental Retardation (M.R. Licensing Law)
Mississippi					
Missouri	X				
Montana			X		Rehabilitation Services
Nebraska	X				Division of Retardation
Nevada	X				Department of Mental Health
New Hampshire					
New Jersey					
New Mexico					

TABLE 5 (Continued)

STATE	YES	NO	STANDARDS IN PROCESS	NO RESPONSE	STATE AGENCY RESPONSIBLE FOR STANDARDS
New York	X				Department of Mental Hygiene
North Carolina					
North Dakota					
Ohio					
Oklahoma					
Oregon	X				Division of Retardation
Pennsylvania			X		Department of Public Welfare
Rhode Island	X				Division of Retardation
South Carolina	X				Department of Mental Retardation
South Dakota	X				Commission on Metal Health and Mental Retardation
Tennessee		X	X		Discussion with Department of Public Welfare
Texas					
Utah					
Vermont					
Virginia					
Wasnington					
West Virginia			X		Department of Mental Health
Wisconsin	X				
Wyoming			X		State Department of Health and S.S.
U.S.Virgin Islands					
Puerto Rico					

or regional standards for activity centers. About five years ago, the University of Alabama staff development project attempted to get such a movement under way through the American Association on Mental Deficiency.

A bright note in this area of licensing and standards is that all centers reported they were inspected by the fire, building and safety, and health departments according to their city or locality ordinance requirements. Thirty-two centers also were inspected by representatives of public school boards of instruction.

DISCUSSION

Roles of Activity Centers

Most, if not all, of the credit for the successful initiation and development of activity centers in this country belongs to the parents of the retarded. Just as the parents made the major breakthrough for diagnostic, education, sheltered workshops and employment programs for the retarded, so have they demonstrated successfully the need and utility of adult activity programs. Through the efforts of associations for retarded children in the 1950's and early 1960's, these programs made their greatest impact on the nation and especially upon the lives of the retarded. Ninety-four centers were established in a 12 year period by associations for retarded children. One-thousand nine hundred thirty-four persons ranging in ages from 16-62 were in the programs.

Without activity centers, many of these individuals undoubtedly would long ago have been placed in institutions. For back in the 1950's, the ages 17-20 represented a difficult time for many families. Their sons or daughters who had been kept occupied in schools now were devoid of service and in need of care. Thus, parents considered institutionalization more and more as their children grew older. Goldstein in 1959 found that the actual rate of institutionalization during the years 20-24 increased sharply. Sheltered workshops and employment programs were able to absorb a few persons in this group, but most retarded in this category were not ready or too handicapped for a workshop type program.

Obviously, persons in this group needed further training in social, personal and vocational areas. To meet the specific needs of these adults, associations for retarded children began establishing adult developmental training programs which are now commonly known as activity centers.

The initial purpose of the activity movement was to provide a place or setting for the adult retarded who were being rejected or discharged by vocational rehabilitation agencies and sheltered workshops (for reasons already stated), so that they would not have to be placed in institutions.

Hence, major emphasis in these early programs was to keep the retarded occupied during the daytime hours in satisfying and socially acceptable activities. Thus, it's not surprising to find that most centers offered program activities in the sphere of rudimentary recreational games, entertainment such as dancing and parties, and spectator sports. Much of the early program emphasis undoubtedly can be attributed to the facts that the staffs were untrained and that the adult retarded populations for activity centers were labeled with "minus signs". Even as late as the 1964 National Study of Activity Centers it was found that nearly one-half of the staff in activity programs were not adequately prepared with experience and education to work with the retarded.

Fortunately, an increasing number of centers changed their program focus in the late 1950's to training in independent personal skills, useful home activities and routines, and community skills including traveling and work—oriented activities. The 1964 National Study revealed that 93 persons went into workshops and employment as a result of these adult development training activities. It is no wonder that a trend to establish more activity centers was seen in 1964, not only to prevent institutionalization, but also to tap severely retarded adult potential which had been left undeveloped. Nevertheless, it still was a pleasant surprise to chart the rapid growth of activity centers from 1964 to 1971 — an increase of 612 programs. Why have these centers grown so rapidly and what are their roles in adult programming for the retarded?

There are many contributing causes. One of the major reasons is that activity programs have very definitive roles in state-wide plans for the continuum of programs and services for the retarded. In addition to preventing institutionalization, activity centers began to enhance public school special education programs for trainable adolescents and young adults by cooperative-joint programming. In some places the schools had the retarded for one-half of the day and the activity center had them the remaining part of the day. In other instances the schools had joint agreements with the activity centers whereby the schools would provide the teachers, the retarded pupils, supplies, transportation, etc., but the activity center would actually provide the supervision and space for the program activities on a daily basis.

Activity programs have promoted also the growth and development of public school classes for trainable retarded persons between the ages of 17-21 years. As a result of a successful prototype class of trainable in this age range which was housed in the Occupation Day Center in New York City by the New York City Bureau for Children with Retarded Mental Development, today public school classes for trainables in the 17-21 year age range exist in all five boroughs in New York City. Much of the program content and justification for these classes came from the first class in the Occupation Day Center. Recently, adult education programs in

States like Florida and California have initiated and staffed activity centers for the older retarded persons.

An increasing number of sheltered workshops and rehabilitation centers have begun to provide activities for their clients who need further training in the personal grooming and social areas in order to be more acceptable on their jobs or to become ready for the sheltered workshop programs. This study identified 41 sheltered workshops and rehabilitation centers which sponsor such activity programs. Since 1964 activity centers have taken on newer roles in providing services for the retarded. For example, in some areas retarded adults who had been institutionalized for many years are being removed from the institutions and placed in supervised community group living homes. Many persons in this group need intensive training in the social and community skills areas and thus a considerable number of activity centers have agreed to provide these services.

Activity programs have become the hub of all regional operations in several places in the country. For illustration the "Sikeston-Delmo Project," in Sikeston, Missouri was initiated in July 1970 in conjunction with the Sikeston Regional Diagnostic Clinic for Mental Retardation. Two community placement programs with this project have been successful in placing 38 female retarded persons from institution into surrogate homes. The community activity centers are used as a hub of all operations connected with the project. The retarded adults are transported to the centers every weekday. Here they are scheduled for many programs such as special education, speech therapy, recreational therapy, arts and crafts, personal grooming, community socialization, behavior modification, and activities designed to stimulate and motivate them so that they can adapt to community and home living situations. The Activity Centers are also an important supplement to the placement projects. Those who are unable to participate in sheltered workshops or other sheltered type employment, may participate in many activities designed to develop or improve skills and always geared to establishing self-confidence and pride in each individual.

Activity Centers are also a part of many regional centers and services for the retarded. Not only do they provide the daytime services already discussed but they also provide a setting for evaluations of retarded adults in daily living activities for clinics, rehabilitation agencies and for the regional centers. In a growing number of places, activity centers are also offering evening social, recreational, vocational and occupational programs in joint endeavors with recreation departments and with adult and vocational education departments of public schools. A few activity centers are also beginning to provide community residential living for those trainees whose parents are deceased. It is anticipated that more and more centers, either as part of the regional program or independently, will offer this service as these adults become older.

It is not presumptuous to say that activity centers have come of age inasmuch as they now have vital roles in adult programming for the retarded. The activity program movement has not only increased dramatically in quantity or numbers of centers but it has improved almost as much in quality in almost all aspects of operations, including the number and quality of staff. There is no doubt that this movement will continue to grow and improve. More community agencies and groups are sponsoring these centers. Similarly there is increased financial assistance given to these centers by Federal, State, County and Community groups.

Present Status of Activity Centers Movement

There were many conclusions made in the first study. One important one was that most activity programs as they were operating then had very serious weaknesses. Similarly, it was stated that there were many unresolved problems; indeed, many not clearly understood.

Some of the glaring weaknesses of the activity program movement were that activity centers were not accepted fully as a good program referral source by most rehabilitation agencies, institutions and even public schools, even though the latter group were discharging and referring severely retarded persons between the ages of 17-21 to activity centers. Today, activity centers are recognized as having important and varied roles in the continuum of programs and services for the adult retarded.

Another weakness discovered in the first study was that many of the selection practices of the centers were not consonant with the known characteristics, composition and needs of the post-school group that they serve.

The second study revealed that an increasing number of centers are more concerned now with whether the applicant can receive maximum benefit from the program rather than whether he precisely meets the criteria for admission. For example, 10 per cent of the centers accept adults with either physical or mental retardation. Likewise, there was no lower limit set to I.Q. for admission in over two-thirds of the programs. And no upper I.Q. limit was set but most centers depend upon functioning ability of applicant to determine eligibility to the program.

This study shows the improvement in the evaluation procedures and process. There is now much greater emphasis on the social history, educational and vocational and psychological evaluations. Likewise, there has been a very marked increase in the importance of providing a trial period as part of the evaluation procedure. Procedures now in operation in activity centers enable the staff to make valid judgments on whether the activity center can help the applicant.

The first study had pointed out that social and psychological services offered by these programs were grossly inadequate. Only a few centers had employed social workers and psychologists. The present study reveals that one-fourth of the centers have a full-time social worker and 32 per cent have at least a part-time social worker. About one-third of the centers have psychologists, although mostly on a part-time basis.

Another glaring weakness in the first study was that nearly one-half of the staffs in activity centers were not academically prepared or trained to work with the retarded. In 1964 fewer than two-thirds of the centers had a full-time director. Now most centers have a full-time director. Those few that do not were found to have a director on a part-time basis. In 1964 very few directors had college degrees, much less a doctorate. The findings in 1971 show that 286 directors and 62 assistant directors had college degrees. All centers also indicated that they had instructors, in fact, 522 were employed in the centers. There has also been a substantial increase in the employment of speech therapists, teachers, teacher's aides, counselors and physical therapists.

The program activities reported in the later study apparently have cleared up many of the doubts voiced in the first study. To recall that criticism, it was concluded that many of the activities considered important in programs at that time were insufficient to attain the stated objectives. Present training activities are considerably different in kind and number, and show a decided change in emphasis. Certainly the objectives of activity centers and training activities are more in tune with the needs, characteristics and potentials of the population they serve.

There has been a marked improvement in the evaluation of the retarded in these centers. In the first study it was discovered that almost three-fifths of the centers did not make their evaluation reports in writing. It was clearly evident that there was little relationship between evaluation and planning within the centers.

In this latest study, nearly all centers evaluated the retarded in a systematic manner. Likewise, about 80 per cent stated that the evaluations were completed in writing and they became a part of the trainee's permanent record. The evaluation and planning become inextricably a part of the total program.

The Road Ahead

This study examined in depth the development and current practices of activity centers as compared to the first national study which was completed in 1964. The deficiencies which were identified in the first study—such as inadequate staff qualifications and evaluation procedures—have now been corrected or remedied in

most areas. However this statement is not intended to imply that there is no further room for improvement.

For example, even though there has been a considerable increase in the social and psychological services provided in the centers, these supportive activities need to be expanded and improved upon in quality. For most families who have members attending these centers, this period in their lives is generally considered to be critical. Good and timely supportive services might just make the difference between success and failure or community living versus institutionalization.

Similarly, there is still a definite need for systematic in-service training opportunities for the centers' staffs. The sharing of experiences on an area, state or regional basis can be most beneficial. Appropriate agencies and groups should conduct the training institutes and the faculty for these sessions could be drawn from the leading activity centers and universities and other facilities located within the area. Resource persons from outside the area could be involved according to the need.

Evidence in both studies supports the utility of activity programs. The rapid growth of these centers can be expected to continue at the accelerated rate. With several thousand applicants on waiting lists to the centers there appears to be a need for more intensive planning and coordinating of programs to services for these persons on an area or regional basis. Activity centers have certainly demonstrated that they serve a vital role in programming for the adult retarded. Yet, there are still many centers that operate on a part-time basis because of financial problems.

Without diminishing present efforts to raise funds from non-government sources, activity centers should receive additional tax support, so they can both eliminate their long waiting lists and also help in the return of thousands of retarded adults from institutions to community living. Institutions for the retarded could facilitate the rehabilitation of this large group by joint working agreement with activity centers for referrals, evaluations and placements.

Activity centers that serve adolescent and young adult trainable retarded persons (14-21 years) should be supported fully by boards of public instruction. The basic right to education for the retarded and the handicapped has been upheld again in the Federal courts in Pennsylvania.

Further refinements must be made in the roles of activity centers for adult programming. It was found that there is still a large number of applicants who are not accepted into programs because they are considered to be too low in mentality. Special attention needs to be given to this group perhaps through several selected demonstration projects. This seems to be a critical need,

especially in light of the new techniques and knowledge in behavior modification programs.

Activity centers need also to constantly appraise their roles so that they do not duplicate existing services. A close examination needs to be made immediately by some centers of the area of programming and also of the populations they serve. With the large waiting lists, the directors and staff should determine if some trainees could be better served in work activity centers, sheltered workshops or other intermediary programs.

Better use could be made of existing recreation and respite resources. Institutions for the retarded have many vacant beds on weekends that could be used for respite care without placing a burden on these facilities. Similarly, parks and recreation departments and other group work programs could further expand to improve their services for the adult retarded. If activity centers could utilize these existing community facilities, a great amount of program space, time and staff would be available in the centers to serve more clients.

Activity centers should think seriously of establishing better written criteria for admission to the centers. This would help sharpen the roles of activity programs and at the same time make clear the responsibilities of rehabilitation and education agencies toward a large population of retarded who now are misplaced in activity centers. Developmental programs aimed at self-care, social adjustment, and economic usefulness should be the main thrust of activity centers. To the extent appropriate to the individual's ability, work or academic training may contribute toward these ends.

Although the staffing models of centers throughout the country were examined, it would be premature and detrimental to the growth and development of activity programs to set forth ideal models for staffing. Staffing models greatly depend on the needs and potential of the population served and the established goals and training activities of the centers. As an illustration, if the center has a profoundly retarded group whose primary needs are in the area of very basic daily living activities, the staffing model for this group could very well be in the disciplines of behavior modification and psychology. The instructors, along with the aides, should be well-versed in these principles. If the center (and it could very well be the same center but with an additional group of persons who functioned on a higher level) was offering community training and work skills, then the basic component of the staffing model would be vocational instructors. Both groups, however, would need supportive psychological, social and medical services which might be obtained through existing community resources. What is being said in effect is that the staffing models should be pertinent to the goals and training needs of the adult population.

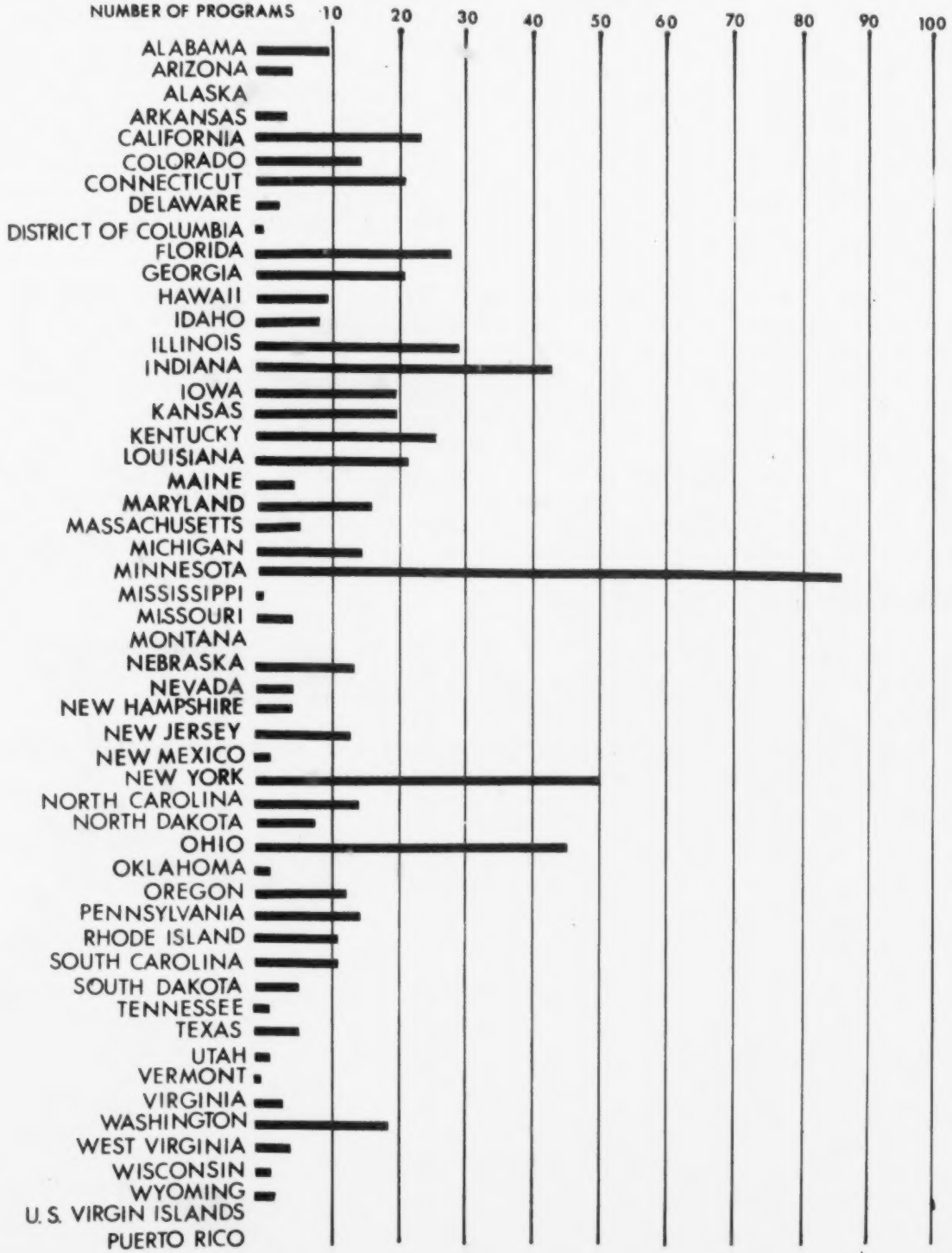
This study found that more and more activity centers have become incorporated as non-profit corporations with their own board of directors. There are also groups other than associations for retarded children which are sponsoring the centers, such as workshops, rehabilitation centers and service clubs, whereas in 1964 almost 80% of the centers were sponsored by associations for retarded children. Along with better financial support from the states and local counties, it is advisable that more centers become non-profit corporations with their own community boards. If this comes about, there will be greater community and consumer involvement and support. Likewise, there will be a greater integration of activity centers into rehabilitation schemes for the retarded and handicapped.

One of the greatest needs seen at the present time is in the area of licensing and setting of standards. Much needs to be done on a state level with regard to licensing these centers. At the same time, national and regional standards have to be developed. The Joint Commission on Accreditation of Hospitals' Accreditation Council for Facilities for the Mentally Retarded currently is developing standards for community services for the mentally retarded. It is understood that these standards, due for publication early in 1973, will encompass adult activity centers along with other types of community facilities. It would be helpful if they provided specific guidelines for measuring the adequacy of adult activity centers in fulfilling their particular role within the spectrum of adult services.

Another and final area of need is to develop program guides for adult activity programs. The guides should deal comprehensively with all aspects of activity program operations.

With these steps, activity centers for retarded adults will continue to grow in both quality and quantity.

National Study of Activity Programs



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